Endoscopic ultrasound-guided fine needle biopsy of pancreatic metastasis from Merkel cell carcinoma

Merkel cell carcinoma (MCC) is a rare and aggressive cutaneous neuroendocrine carcinoma. The incidence rate is approximately 0.3–0.6/100,000 per year [1, 2]. At initial presentation most patients with MCC (70%–80%) have localized disease, and only a few (1%–4%) have distant metastases [3]. Moreover, MCC rarely metastasizes to the pancreas, therefore this represents a challenge for the differential diagnosis of pancreatic masses [4].

A 73-year-old man reported epigastric pain and vomiting. The patient’s history included a diagnosis of an MCC, which had been removed from his left elbow 7 months before the onset of his upper gastrointestinal symptoms. His laboratory findings were unremarkable. An abdominal computed tomography (CT) scan showed a lesion infiltrating the common bile duct (CBD) and dilatation upstream of the lesion. The patient underwent an endoscopic ultrasound (EUS), which confirmed a 3-cm hypoechoic, heterogeneous, irregular mass with evidence of invasion of the portal confluence (● Fig. 2; ● Video 1). Three needle passes, using a “fanning” technique followed by slow withdrawal of the stylet, were performed with a 22-gauge ProCore needle.

Cytohistological evaluation of the samples revealed small blue, round-to-oval cells with stippled chromatin (● Video 2). Cytological evaluation of the samples showed a lesion infiltrating the common bile duct in the pancreatic head, without vascular involvement, which was considered to be a possibly resectable adenocarcinoma (● Fig. 1).

The patient underwent an endoscopic ultrasound (EUS), which confirmed a 3-cm hypoechoic, heterogeneous, irregular mass with evidence of invasion of the portal confluence (● Fig. 2; ● Video 1). Three needle passes were performed with a 22-gauge ProCore needle (Cook Medical, Winston-Salem, North Carolina, USA) using a “fanning” technique followed by slow withdrawal of the stylet (● Video 2). Cytological evaluation of the samples revealed small blue, round-to-oval cells with stippled chromatin (● Fig. 3a). The cells were positive for CK20, sinaptophysin, and chromogranin, and had a Ki-67 index of >60%, suggestive of pancreatic metastasis from MCC (● Fig. 3b).
In this specific case, the EUS features of the pancreatic metastasis from MMC mimicked a classic adenocarcinoma. Moreover, this neoplasm showed few specific cytologic features as the same small blue, round-to-oval cells can also be seen in lymphoma or small cell carcinoma [5]. Given that CK20 is a pathognomonic marker of MCC [4,5], obtaining an adequate tissue sample for immunohistochemical evaluation with the use of an EUS-guided histology needle was key for making the differential diagnosis. To the best of our knowledge, there are no other reports in the international literature of a pancreatic metastasis from MCC being diagnosed by EUS-FNB.

References

Competing interests: None

Antonella Maimone1, Maria Luisa Bianchi1, Paola Lorenzini2, Annalisa de Leone2, Luca De Luca1
1 Gastroenterology and Digestive Endoscopy Unit, A.O. “Ospedali Riuniti Marche Nord”, Pesaro, Italy
2 Department of Pathological Anatomy, A.O. “Ospedali Riuniti Marche Nord”, Pesaro, Italy

Corresponding author
Luca De Luca, MD
Gastroenterology and Digestive Endoscopy Unit
A.O. “Ospedali Riuniti Marche Nord”
Piazzale Cinelli 1
61121, Pesaro
Italy
Fax: +39-072-1362285
lucadeluca1210@gmail.com